REFLECTIONS DENTAL CENTRE

DENTAL INSURANCE INFORMATION

Please fill out all applicable information

PRIMARY Insurance _____ Employer _____

Policy Holder's Name _____ Date of Birth _____

Group Number _____ ID/Certificate/Student _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

SECONDARY Insurance _____ Employer _____

Policy Holder's Name _____ Date of Birth _____

Group Number _____ ID/Certificate/Student _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

So that we can be accurate in our estimates of cost, we strongly recommend that you print out the specific coverages of your insurance policy from their website and bring it to your appointment. They will not share this information with us directly. NO policy is designed to cover all fees.

It is important to realize that dental insurance benefits are a contract between you, your employer, and the dental insurance company. Any balance not paid by the insurance company is the responsibility of the client.

I have read and understand the above information. I assign benefits payable for services rendered to Dr. Graham D. Hill Inc. I accept full responsibility for any fees not paid by my insurance company.

Signature: _____ Name (printed): _____

Date: _____